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Gulf Coast Obstetrics & Gynecology of Sarasota, LLC
Voluntary Compliance Program

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PURPOSE & OVERVIEW: *Our practice has adopted a voluntary compliance program, which is intended to promote adherence to statues and regulations applicable to the Federal health care programs and their requirements. Our goal is to provide a basic tool to strengthen the efforts of our providers and prevent and reduce improper conduct. These guidelines, developed using materials provided by the Office of the Inspector General (OIG), will help ensure that our HCFA claims submitted to the Federal health care programs are true and accurate. All of us at the practice of Gulf Coast Obstetrics & Gynecology of Sarasota, LLC share the responsibility to prevent fraud and abuse at all times. Everyone is required to read and understand the guidelines below and report any suspected or known abuses immediately, without fear of retribution. Working together, we can assure our practice remains compliant while delivering quality health care to all our patients.*

1. The practice will conduct periodic audits and chart reviews specifically from a compliance standpoint.

   A. Standards and Procedures: The practice will utilize current Government regulations or compendiums generally relied upon by physicians and insurers: CPT and ICD-10-CM codes

   B. Claims Submission Audit: The practice will periodically perform self retrospective audits to review the following:

   - ensure that bills are accurately coded and accurately reflect the services provided as documented in the medical record
   - ensure that documentation is being completed correctly
   - ensure that services or items provided are reasonable and necessary
   - ensure there are no incentives for unnecessary services

2. The practice will ensure corporate compliance in billing and recording keeping

   A. Specific Risk Areas: The practice will focus on the four major areas of fraud and abuse:

   - improper coding and billing

   *billing for items or services not rendered or not provided as claimed
   *submitting claims for equipment, medical supplies and service that are not reasonable or necessary
   *double billing resulting in duplicate payments
   *billing for non-covered services as if covered
   *knowing misuse of provider identification numbers, which result in improper billing
   *unbundling (billing for each component of the services instead of billing an all-inclusive code
   *failure to properly use coding modifiers
   *clustering
   *up coding the level of service provided

   - providing unreasonable and unnecessary services

   *Practice will use Medicare standard of being reasonable and necessary for diagnosis and treatment of a patient

*The medical record should support the appropriateness of a service that the provider has provided

- improper documentation

*The medical record must be complete and legible
*The documentation of each patient encounter should include the following:

a. reason for the encounter
b. any relevant history
c. physical examination findings
d. prior diagnostic test results
e. assessment
f. clinical impression or diagnosis
g. plan of care
h. date and legible indentity of the observer

*If items above are not documented, the rationale for ordering diagnostic and other ancillary services can be easily inferred by an independent reviewer or third party who has appropriate medical training.
*Documentation and the medical record support CPT and ICD-9-CM codes used for claims submission
*Appropriate health risk factors are identified as well as the patient's progress, his or her response to, and any changes in, treatment and any revision in diagnosis are documented.
*The CPT and ICD-10-CM codes reported on the health insurance claims form should be supported by documentation in the medical record and the medical chart should contain all necessary information.
*HCFA and the local carriers should be able to determine the person who provides the services.
*The following practices will ensure that the HCFA form has been properly completed:

a. link the diagnosis code with the reason for the visit or service
b. use modifiers appropriately
c. provide Medicare with all information about a beneficiary's other insurance coverage under the Medicare Secondary Payor (MSP) policy, if the practice is aware of a beneficiary's additional coverage.

- improper inducements, kickbacks and self-referrals

*In general the anti-kickback statue prohibits knowingly and willfully giving or receiving anything or value to induce referrals of Federal health care program business.
*Examples of improper inducements include:

a. Routinely waiving coinsurance or deductible amounts without a good faith determination that the patient is in financial need or failing to make reasonable efforts to collect the cost-sharing amount.
b. Financial arrangement with outside entities to whom the practice may refer Federal health care program business.
c. Joint ventures with entities supplying goods or services to the physician practice or it's patients.
d. Consulting contract or medical directorships
e. Office and equipment leases with entitles to which the physician refers
f. Soliciting, accepting or offering any gift or gratuity of more than a nominal value to or from those who may benefit from a physician practice's referral of Federal health care program business.

*Medical Record Retention

a. Medical records will be maintained as described per the Federal and Florida Statutes.
b. Medical records will be secured against loss, destruction, unauthorized access, unauthorized reproduction, corruption, or damage.

3. The practice administrator will serve as compliance contact for the practice with the following duties:

- Overseeing and monitoring the implementation of the compliance program
- establishing methods, such as periodic audits, to improve the practice's efficiency and quality of services, and to reduce the practice's vulnerability to fraud and abuse.
- periodically revising the compliance program in light of changes in the needs of the practice or changes in the law and in the standards and procedures of Government and private payor health plans.
- developing, coordinating and participating in a training program that focuses on the components of the compliance program, and seeks to ensure that training materials are appropriate.
- Ensuring that HHS-OIG's List of Excluded Individuals and Entities, and the General Services Administration's (GSA's) List of Parties Debarred from Federal Programs have been check with respect to all employees, medical staff and independent contractors.
- Investigating any report or allegation concerning possible unethical or improper business practices, and monitoring subsequent corrective action and/or compliance.

4. The practice will conduct appropriate training and education on practice standards and procedures periodically.

- There are three basic steps governing compliance training for the practice:

*determining who needs training (both in coding and billing and in compliance)
*determining the type of training that best suits the practices needs (e.g. seminars, in-service training, self-study or others)
*determining when and how often education is needed and how much each person should receive.

- Some examples of items that could be covered in coding and billing training include:

*coding requirements
*claim development and submission processes
*signing a form for a physician without the physician's authorization
*proper documentation of services rendered
*the legal sanctions for submitting deliberately false or reckless billings

5. Detected compliance violations or allegations shall be invested immediately and disclosure made of such incidents to the appropriate Government entities

- Violations of a physician practice's compliance program, significant failures to comply with applicable Federal or Sate law, and other types of misconduct threaten a practice's status as a reliable, honest and trustworthy provider of healthcare. Consequently, upon receipt of reports or reasonable indications of suspected noncompliance, it is important that the compliance contact look into the allegations to determine whether a significant violation of applicable law or the requirements of the compliance program has indeed occurred, and, if so, take decisive steps to correct the problem.

6. The practice will have open lines of communication with the staff through meetings and use of bulletin boards to keep employees updated regarding compliance activities.

- Our practice has a clear "open door" policy between the physicians, compliance personnel and practice employees.

- Employees are required to understand and do the following:

  *report conduct that a reasonable person would, in good faith, believe to be erroneous or fraudulent.
  *their ability to anonymously report fraudulent conduct to compliance officer
  *failure to report fraudulent conduct is a violation of the compliance program and is illegal
  *that there will be no retribution toward any employee reporting conduct that a reasonable person acting in good faith would have believed to be erroneous or fraudulent.

- The practice will strictly enforce disciplinary standards through clearly understood and published guidelines.

  *Disciplinary actions for failure to report compliance violations may include any or all of the following:

  a. Warnings (written and oral)
  b. Probation
  c. Temporary suspension without pay
  d. Termination
  e. Referral for criminal prosecution

ALL PRACTICE EMPLOYEES SHOULD BE FAMILURE WITH THE INFORMATION INCLUDED IN THESE GUIDELINES. ADDITIONAL, DETAILED DESCRIPTIONS FOR THE ABOVE INFORMATION WITH FUTHER EXAMPLES ARE LOCATED IN THE ADMINISTRATOR'S BOOKCASE FOR YOUR REVIEW AT ANY TIME. THIS INFORMATION IS PROVIDED BY THE OFFICE OF INSPECTOR GENERAL (OIG).

***FRAUD IS A CRIME,** AND WILL NOT BE TOLERATED AT ANY LEVEL AT THE PRACTICE OF GULF COAST OBSTETRICS & GYNECOLOGY OF SARASOTA, LLC.*